EHN CANADA

CONCURRENT TREATMENT: EATING & SUBSTANCE USE DISORDERS

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WEBINAR GOALS

Goal #1

Make the case for concurrent treatment

Goal #2

Overview of concurrent treatment at Bellwood

Poll #1 – Who is tuning in today?

Poll #2 – Do you work for a hospital organization, community-based organization, or independent/private practice?

Poll #3 – What area of practice do you work in?

New data…

Demand for mental health support for Ontario adults increased by **47%** between 2021-2022

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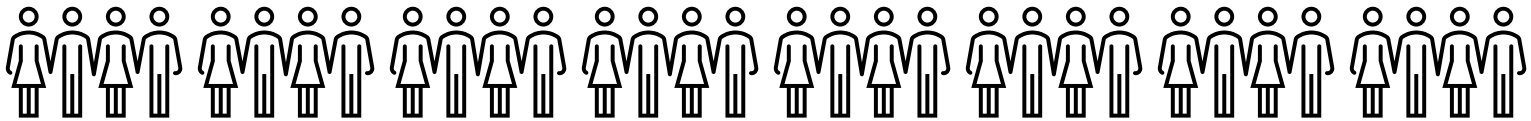
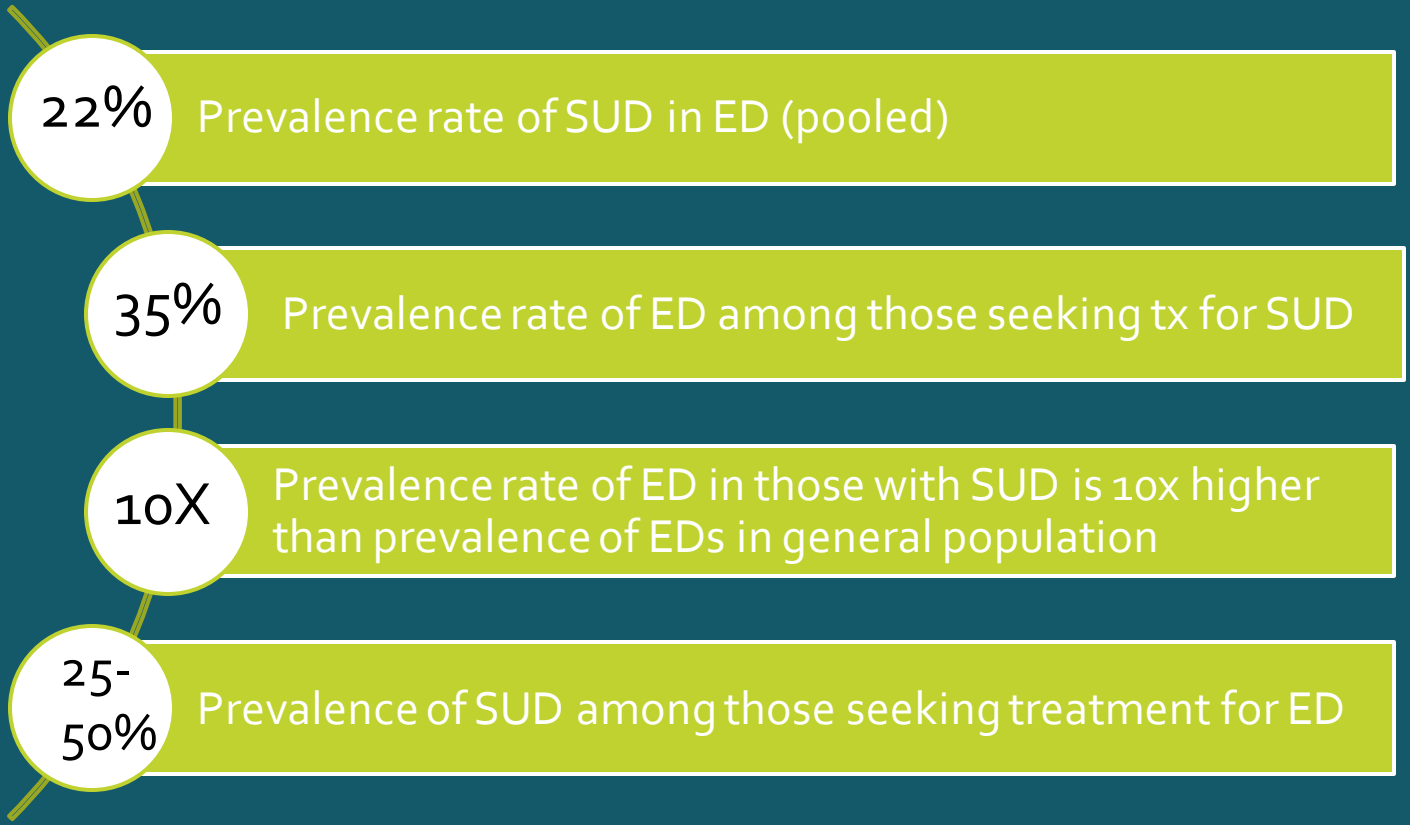
ED & SUD – PREVALENCE & IMPACT

Overall prevalence rates

- Eating Disorders (AN, BN, BED, ARFID, OSFED)
  - Estimated 1 million Canadians
- Substance Use Disorders
  - Estimated 6 million Canadians (lifetime)
  - Estimated 10% of Ontario population have problematic use

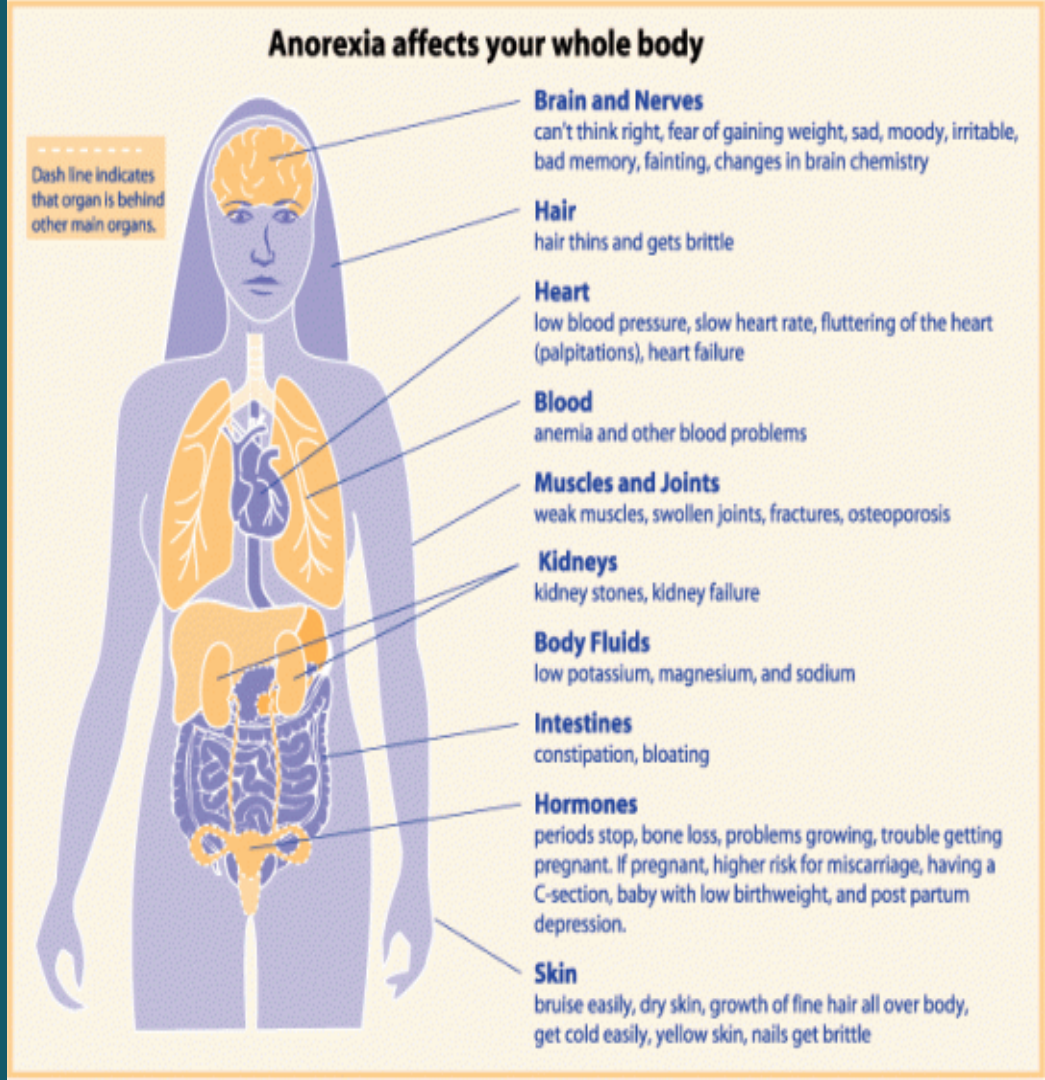


Prevalence of ED & SUD combined



Body system impact of ED

- Medical
- Psychological

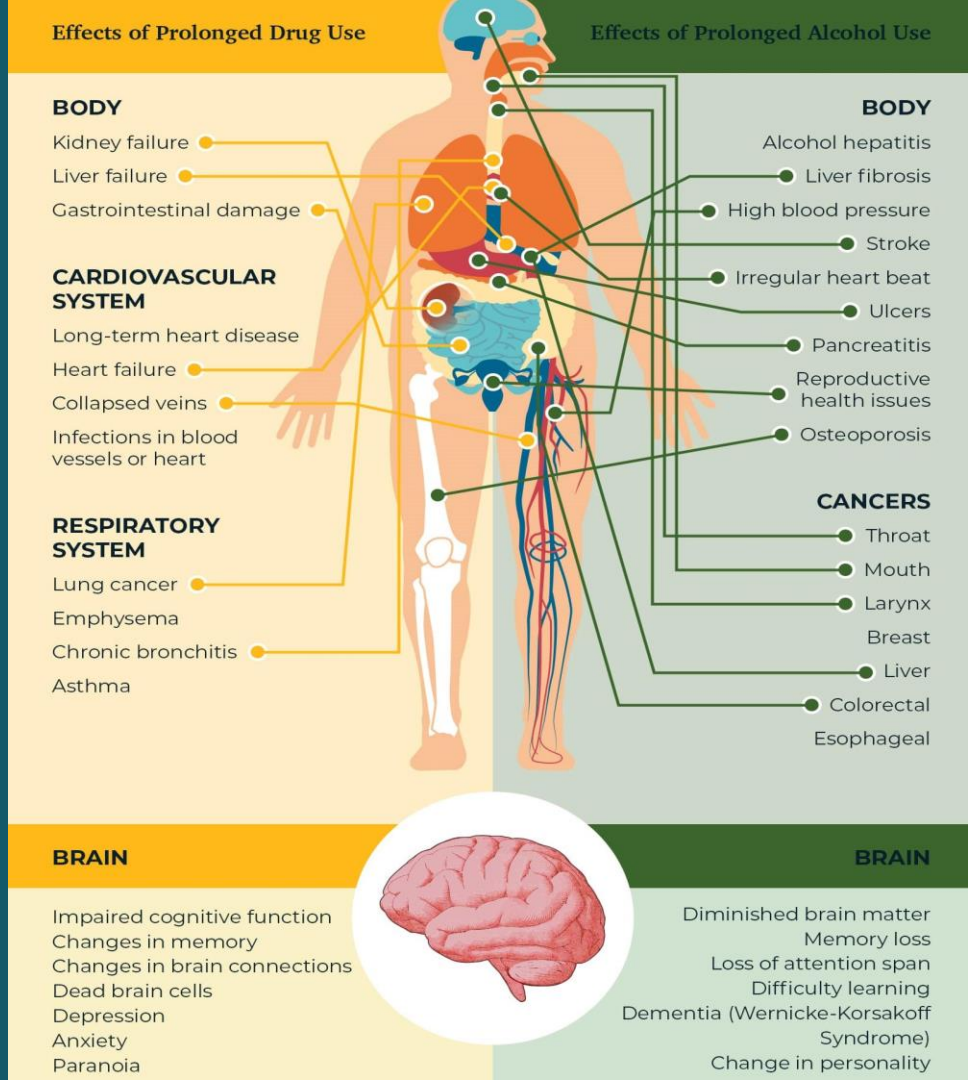


Mortality rates in ED

- Highest overall mortality rate of any mental illness
  - Estimated between 10-15%
  - Estimated 10% of those with AN will die within 10 years of disorder onset
- Cardiac disease is leading cause of death in AN
- Suicide is second leading cause of death in AN
  - 20% with AN will attempt in their lifetime
  - 25-35% with BN will attempt in their lifetime
- Mortality rate in females aged 15-24 with AN is 12x > all other causes of death combined

Body system impact of SUD

- Medical
- Psychological



Mortality rates in SUD

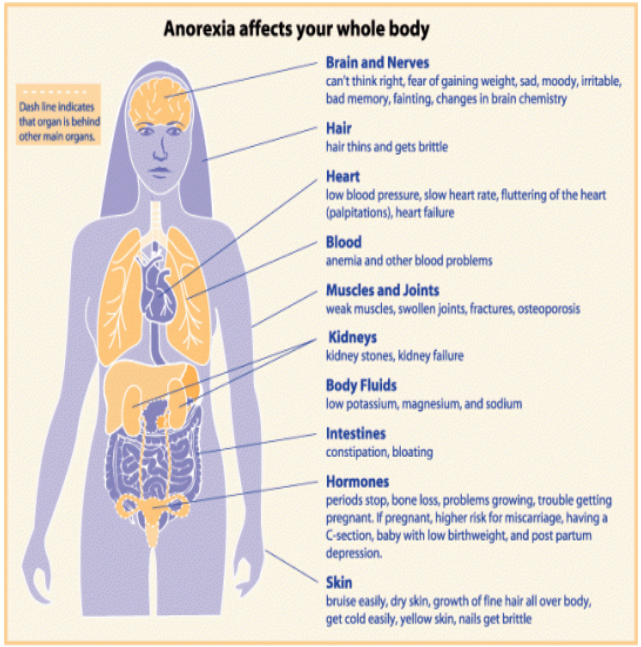
67,000 deaths/year in Canada

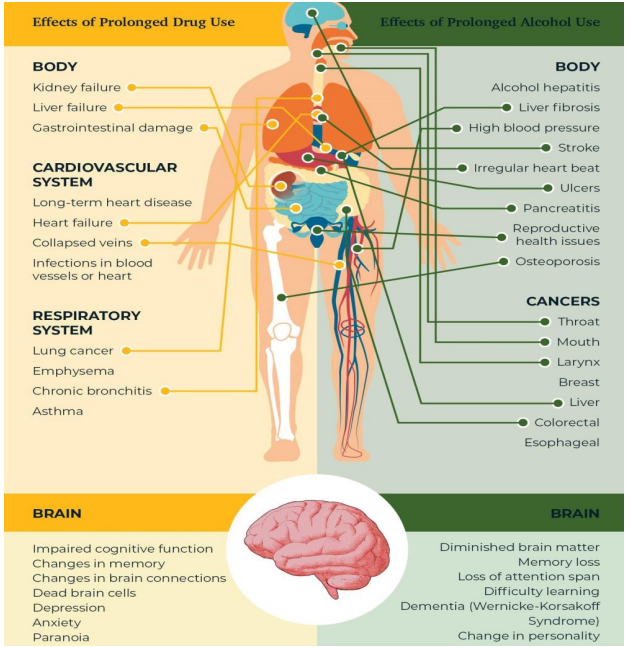
15,000 alcohol related

14,700 opioid related

Impact of concurrent ED & SUD

No body system is safe





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ED & SUD combined is more lethal than either disorder alone

Mortality rates in concurrent ED & SUD

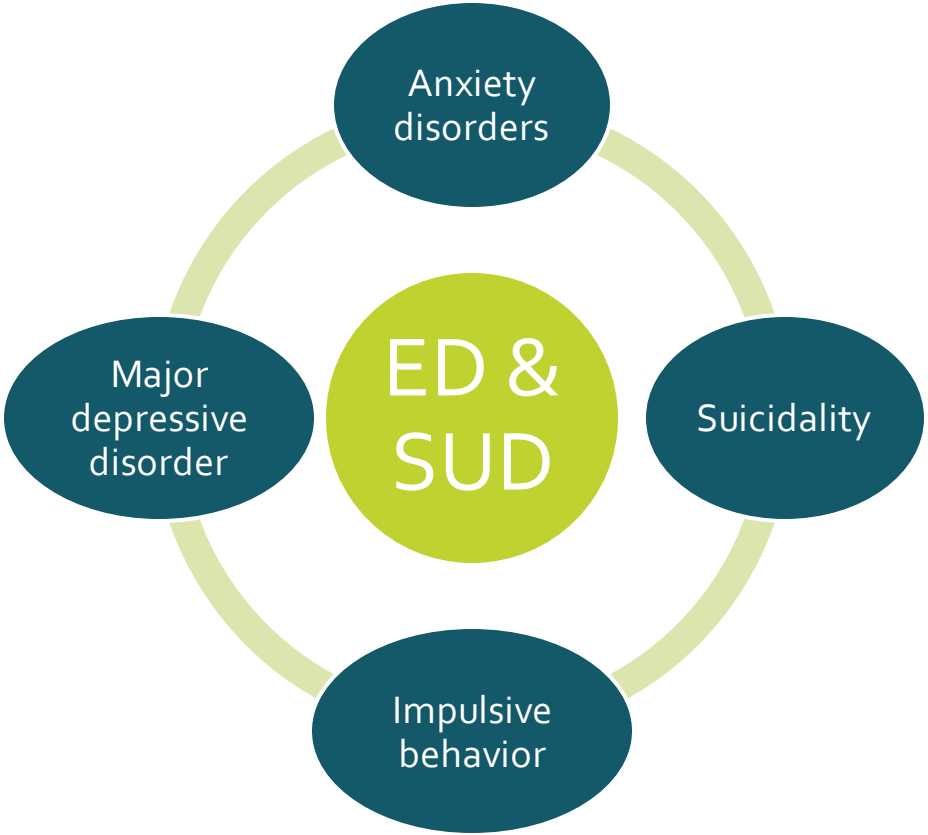
All-cause mortality rates

- AN
  - Without SUD – 3.21X higher
  - With alcohol use disorder or cannabis use disorder – 11.28X higher
  - With hard drug use disorder alone or with alcohol/cannabis use disorder – 22.43X higher
- BN
  - Without SUD – similar to controls
  - With alcohol use disorder or cannabis use disorder – 5.86X higher
  - With hard drug use disorder alone or with alcohol/cannabis use disorder – 11.43X higher
- Unspecified ED
  - Without SUD – 4.75X higher
  - With alcohol use disorder or cannabis use disorder – 10.86X higher
  - With hard drug use disorder alone or with alcohol/cannabis use disorder – 15.53X higher

Undiagnosed ED & SUD significantly impact AMA rates

SHARED RISK FACTORS & COMORBIDITIES

Shared comorbidities



Shared risk factors with ED & SUD

Biological (genetic)

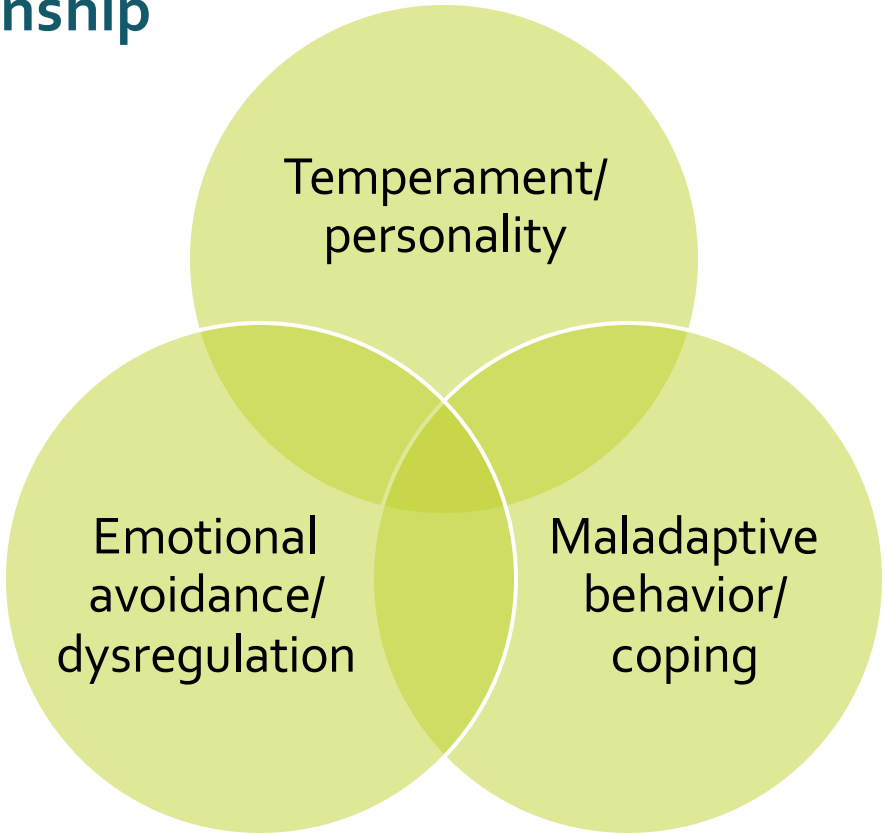
Psychological

Sociocultural

Temperament & personality

Trauma

Shared relationship in ED & SUD



Trauma

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CHALLENGES WITH CONCURRENT TREATMENT

Challenges with concurrent treatment – the disorders

- Complex disorders even when not co-occurring
- Additional psychiatric factors often present (depression, anxiety, trauma)
- Chronicity & relapse rates
- High risk medically & psychologically
- Denial & treatment resistance

Challenges with concurrent treatment – the system

- Lack of concurrent programs
- Lack of specialized training opportunities
- Strength of evidence
- Silos in treatment and areas of expertise
- Sequential treatment
- Impact on efficiency and effectiveness of treatment and long-term treatment outcomes

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BELLWOOD HEALTH SERVICES

Treatment programs


BELLWOOD

Clinical team

- Physicians
- Nurse Practitioner
- Psychiatry
- Nurses
- Mental Health & Addictions Support Workers
- Physical Health
- Registered Dietitian
- Nutritionist
- Substance Abuse Workers
- Addictions Counsellor
- Social Workers
- Registered Psychotherapists
- Occupational Therapists
- Client Navigator
- Case Coordinator
- Research Coordinator

Treatment programs

Core Program	•7-week treatment •CBT, DBT skills, relapse prevention
Mood & Anxiety Program	•7-week treatment •CBT, ACT, DBT skills, OT sessions
Trauma Recovery Program (Core or MAP stream)	•8-week treatment •CPT •Core or MAP content
Return to Wellness Program	•14-day treatment •Intro to skills groups •Transition to Intensive Outpatient Services
Comeback Program	•10-day treatment •"Booster" program after a period of stability •Skills enhancement
Obsessive Compulsive Disorders Program	•Partnership with Sunnybrook Health Sciences Centre •Hybrid inpatient and day treatment
Eating Disorder Program	•Coming up!

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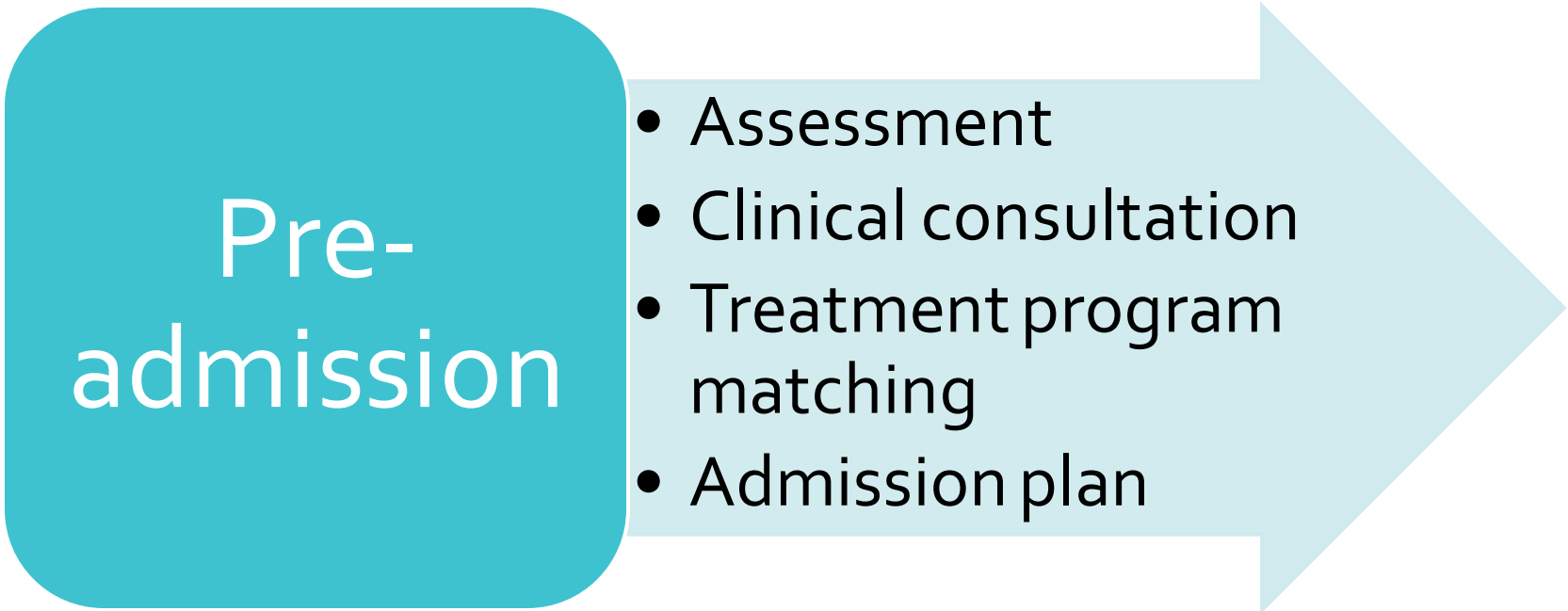
Treatment journey



Treatment journey

During treatment

- Nursing and medical assessment
- 24/7 medical care + support staff
- Psychiatric assessment (if required + program specific)
- Detox and stabilization (if required)
- Holistic treatment programming
- Post-treatment planning

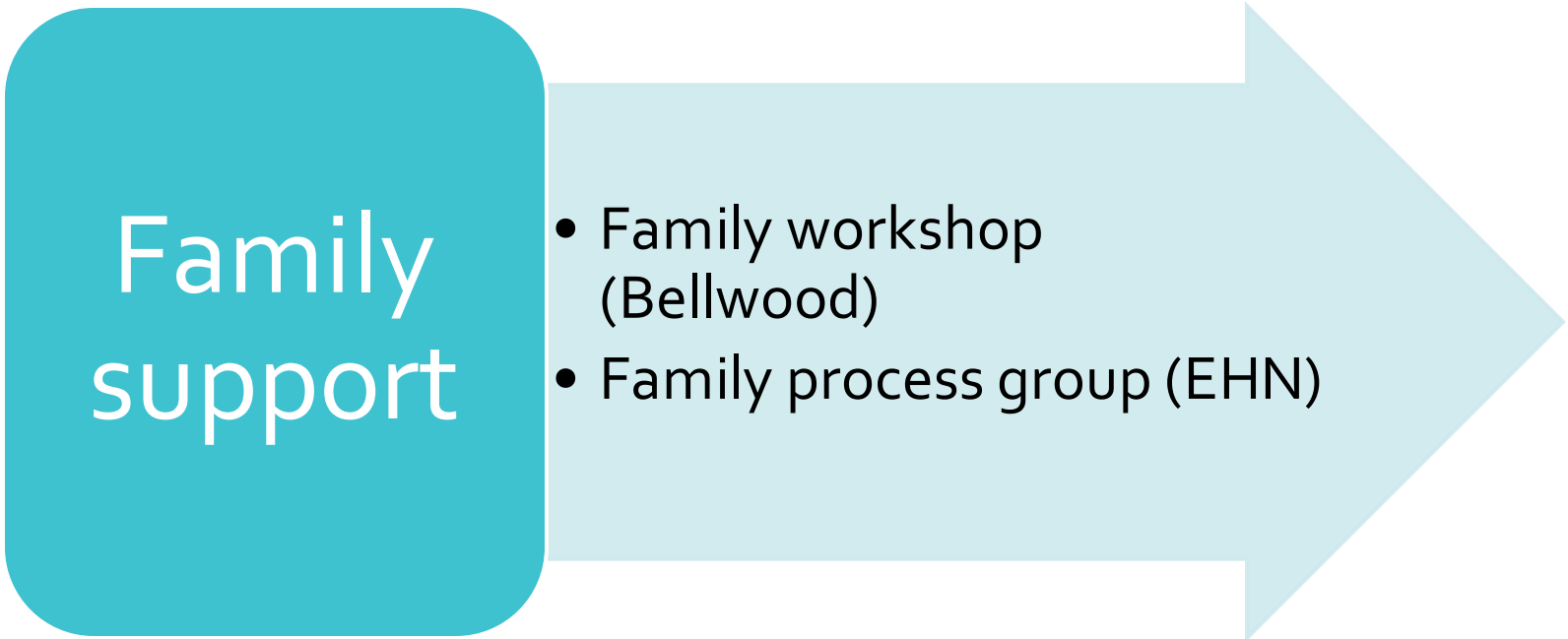
Holistic treatment programming

- Trauma informed care
- Primary group therapist(s)
- Primary individual therapist
- Nutritional support
- Health teaching and education
- Art therapy
- System navigation

Holistic treatment programming

- Physical health (gym, nature walks, yoga, meditation, team sports, etc.)
- Wellness (acupuncture, massage therapist, chiropractor)
- Self-help groups (AA, GA, NA, Smart)
- Recovery community
- Relapse prevention and post-treatment planning

Treatment journey



Treatment journey

ED PROGRAM

The ED team

"Mini team"

- ED psychiatrist
- Psychotherapists
- Registered Dietitian
- Nutritionist
- Mental Health & Addiction Support Workers

The ED program

- Referral – self-referral, physician, referent partner
- Pre-admission psychiatric assessment
- 8-week (+) treatment program
- Goal-based care
- Consistent psychiatry support

Concurrent ED treatment

- What does the client need?
  - Concurrent mood or anxiety disorder?
  - Concurrent substance abuse disorder?
  - Concurrent trauma history or PTSD?
  - Concurrent process addiction?
  - Will the client benefit from relapse prevention skills?

In-depth assessment is key to creating a concurrent, goal-based treatment program

Concurrent ED treatment

- Psychotherapy and skill acquisition
  - Group therapy
    - DBT, CBT
    - Specialty groups - body image, meal planning, process groups
    - Exposure work
  - Individual therapy
    - Deeper dive
    - Enhance skills
    - Exposure work
- Family therapy sessions

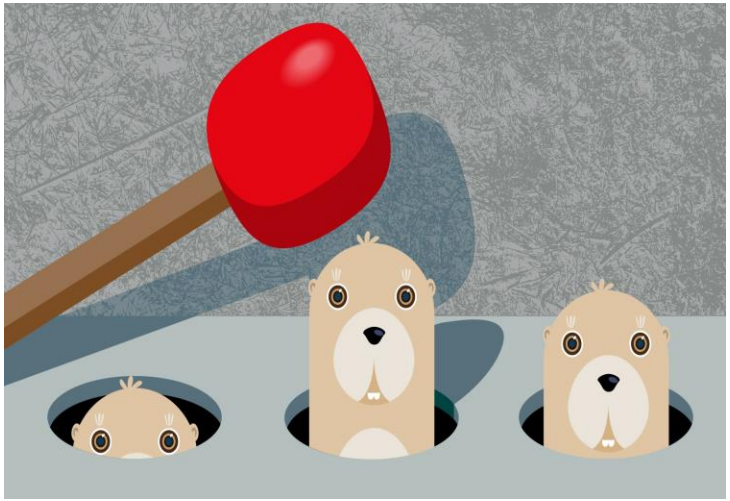
Concurrent ED treatment

- Symptom interruption
- Symptom monitoring
- Weight stabilization
- Physical health sessions
  - Customized to individual needs

Nutritional rehabilitation

- Nutrition education
- Meal support
- Meal planning
- Exposure work
- Skill translation

KEY MESSAGES



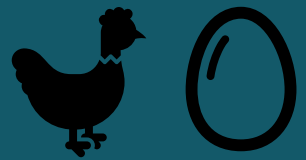
So…why concurrent treatment?

- Continuity of care
- Client experience
- Reduced relapse risk
- Optimal clinical outcomes
- Long-term recovery
- Reduced mortality rate
- Better social and economic outcomes

Key messages

- Screen and assess for both ED and SUD
- Identify treatment opportunities
- Examine silos in practice and bridge gaps
- Invest in training and education
- Advocate for services and programs
- Invest in research
- Need for evidence-based treatment support

It needs to be the chicken AND the egg, not one or the other



QUESTIONS?